

## **The psychological and cultural place of self-injury**

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### **Summary**

Self-injury is ubiquitous and universal. It is often considered a source of pride when it is carried out under the eyes of the public or officialdom, and when a person injures themselves to gain culturally approved ends. These ends include anatomical change, decoration, or the pursuit of development or transcendence. By contrast, problematic self-injury is concealed and so becomes private. It is carried out by the person themselves or an assistant and its scars are hidden as being a source of shame. There is a resistance to all self-injury which we term the 'safety catch'. Society provides 'directions' about the circumstances in which this safety catch can be released. We consider the nature of these directions and how a person on their own, and without social direction, might overcome this resistance.

### **Introduction**

For most people, even imagining cutting oneself deliberately until the blood flows, or pouring boiling water over one's own arm causes a shivery kind of feeling. Consequently, most of us find it rather disturbing to witness self-injury in other people, and the same is often true of health and social care staff unless they have become familiar with injures and with repeated self-injury. As we shall see, familiarity with injures, injuries and injure care can lead to a blunting of this reaction in health professionals, but a staff member who is not (or who is no longer) familiar with injures may still be empathetically provoked into thinking what it would be like if it was his or her own skin that was being cut or burnt.

Many people feel an emotional repugnance to having these things happen to themselves or to seeing their consequences afterwards, and this produces a resistance to putting themselves in a situation when there is a risk of this occurring. This resistance is a recurring theme in this chapter, and we use the term 'anti-trauma safety-catch' to describe it, or sometimes in this book just 'safety-catch'.

### **Culture and self-sought injury**

It can be a surprise to realize that self-inflicted damage to the skin and underlying tissues is not just tolerated in one form or another in almost every culture, but is often considered socially appropriate or even socially desirable. For example, Favazza (1996) observed that African tribal women who traditionally mutilate themselves are often held in regard by other tribal members. German students in the 19<sup>th</sup> century acquired status through having a facial scar and would cut each other with sabres to obtain this according to Menninger (1935).

The social functions of self-sought injury include the following:

***(a) Healing***

Bloodletting has been (and still is) widely used in attempt to cure physical and psychological complaints. Members of a Moroccan healing sect are known to slash open their own heads in attempt to cure their patients, and men in Papua New Guinea attempt to purify themselves through penis cutting and tongue abrasion. Boys from the Gahuka-Gana tribe, also in Papua New Guinea, become initiated into adult life by enduring the painful ritual of inserting sticks and leaves up their noses to induce haemorrhaging, thereby cleansing themselves in a way seen as related to menstruation in females. The Bushman tribe in Africa continue to believe sickness can be cured by removing parts of the fingers, and some South African peoples consider that headaches may be treated and evil spirits released by drilling a small hole in the skull (a procedure termed trepanning or trephination) although this is not often self-administered.

***(b) Religious ceremony***

Self-injury is often an important element of religious ceremony, as we have noted. Its purpose is rarely stated explicitly. The intention has sometimes been to purify, as in the many instances of self-castration for religious reasons. Sometimes it has been a test of faith through ordeal: Favazza (1996) gives many examples such as the Christian martyrs who sought self-mortification, the thigh cutters in China, and candidates for shaman status from in Siberia and among native Australians Aborigines who are required to endure extreme rituals that include dismemberment and scraping away the flesh after which it is believed they will be able to heal others. Self-injury has also been a way of producing the blood that has religious significance and potency.

***(c) Commemoration***

In New Guinea, young girls of the Dugum Dani tribe cut off their fingers as a sacrifice at funerals, and for some African tribes, where the same is done, the amount of finger amputated indicates the closeness of the relationship with the deceased person.

Religious self-injury may also be commemorative. For example, Shi'ite Muslims commemorate the annihilation of an army led by Ali, the son-in-law of the Prophet Muhammed and his son, Husayn by an army led by the Umayyad Caliph, Yazid. Four years later a small group of Husayn's followers (the Penitents) went to the battlefield to mourn his death and, according to some commentators, to make atonement for their failure to aid Ali and Husayn (Aslan, 2006). The Penitents attracted other Muslims who recognized Ali as the first Iman and the true successor of the Prophet and not the successor recognized by mainstream or orthodox ('Sunni') Muslims for whom that is the first Caliph, Abu Bakr. Since then many regional, political, theocratic and theological differences have grown up to separate Sunni and Shi'ite Muslims, but the observances commemorating Karbala continue to be a trigger point for active confrontation. They occur during the first ten days of Muharram culminating on the 10<sup>th</sup> day, with lamentation assemblies and mourning processions (matam) in which the mourners beat their breasts or flog themselves with chains to which knives are sometimes tied ('zanger-zani'). Aslan (2006) argues that there is a difference between this self-flagellation and that of the Christian Flagellantes of the Middle Ages in that the aim is not to experience pain, but to bleed and thus show the flagellant's identification with the martyrs of Karbala. Apparently many municipal authorities lay on mobile blood donation stations at matam and encourage the mainly young men who march in the processions to give blood rather than spill it, although he does not say how successful this is.

#### ***(d) Decoration***

Damaging the skin by cutting, piercing, or abrading for the purpose of decoration is common to every culture. Many in the West take ear piercing so much for granted that it seems as if it is not a kind of self-injury. Tattooing and piercings elsewhere, which were once marginal activities in the West, are now mainstream; tattooing parlours and piercing salons can be found in most shopping centres in the developed world.

#### **The safety-catch and the 'shock' of self-injury**

Some of our readers may object to our promiscuous lumping together of the different reasons that people cut themselves, or invite others to cut themselves. Piercing an ear lobe might seem to these readers very different to, say, cutting the wrist. We do not think that they are qualitatively different. The risk of infection applies to both, and wrist cutting – or rather forearm cutting since that is the more preferred site – carries as low a risk of severe injury or death as does ear piercing. The difference between the two is that our shiver when we think of having an ear pierced is a great deal less strong than when we think of cutting our wrist. Familiarity and cultural acceptance have weakened our safety catch when it comes to injury to the ear lobe, but the safety remains fully on when it comes to injury to our wrist.

When is it right for the safety catch to be turned off? As usual, the answer to this question depends on what we mean by right. We shall see later that some people who injure themselves to relieve their feelings sometimes consider that they are in the right to do so. There are others who would not consider it right to pierce the ears simply for decorative purposes because that would be seeking to improve on God's creation.

Most people, though, go along with what is customary in their own culture, which is to say that they are aware of their culture's norms, or rules, and consider that these define the right and wrong circumstances for self-injury. These norms are often reinforced by social arrangements such as ceremonials in which there are clear directions about who injures themselves, how, and how much. Whilst these 'social directions' cannot overcome the safety catch, they can regulate what happens when the safety catch is bypassed or overcome.

## **Anatomical rearrangement**

### ***(a) Surgery***

Surgery is a good example of injury carried out under social direction. The aim of surgery is to change anatomy; often to remove a part of the body, or to sever or join up fluid-containing pipes or tubes. Surgery usually takes place on internal organs, in which case the skin is cut simply in order to gain access. Surgery is usually carried out by others, although in extreme circumstances it is possible to carry out surgery on oneself. Having surgery is not usually a secret activity, and the aims of the surgery are socially sanctioned. These aims may be cosmetic (to enhance a person's appearance) but are most often therapeutic (to prevent ill health).

Recently a well-publicized autobiography described a dramatic escape from being trapped by the leg following a rock fall. The young author described his decision to amputate his own leg, which he eventually succeeded in doing, and was then able to get free and walk with the aid of an improvised crutch to the nearest settlement. Critical opinion about the action was divided. On the one hand it seemed an extraordinary act of courage to overcome the safety catch in that way. On the other hand, there was suspicion because the act was not socially directed, as surgery normally is. Could this really be an act of self-mutilation?

As we shall see, there are many deliberate injuries that are intermediate between surgery and repeated self-injury in that they are more like surgery or more like repeated self-injury on one or more of the following characteristics: anatomical rearrangement, having the skin as target, done by self or other, secret or public, and socially sanctioned or privately sanctioned (see Table 2.1). We will consider injury that aims at anatomical rearrangement in the sections that follow. This does not just include surgery, but also mutilations carried out for punishment and self-mutilation.

Therapeutic surgery may be designed to remove a part that is diseased and which would cause damage to the whole body and even death if allowed to remain. But therapeutic surgery may also be used to remove a part that is undesirable, and which may be seen as the cause of bad behaviour or bad consequences. Surgical castration has been used to treat men who have committed sexual offences attributed to an excess of male hormone, for example.

### ***(b) Being mutilated by others***

This kind of surgery comes close to mutilation used as punishment when a part of the body that is linked to the offence is removed. The Hammurabi codex, the oldest extant legal text known, incorporates mutilation as punishment; for example, a man who falsely slanders a man's wife or a temple prostitute will have his brow marked. To this day Muslim Sharia law includes amputation of the hand in its list of punishments, and Sharia courts have also ordered blinding as a tit for tat punishment of someone who blinded someone else.

Amputation of the tongue has been used as a punishment for loose or treacherous talk, although it may also have served as a convenient method of ensuring someone's secrecy in an illiterate age when the only means of symbolic communication was by speech. Cutting out a person's tongue ensures that they cannot pass on any secrets in the future, but like many mutilations it has an additional meaning – that of cutting out a part of the body that has done harm, the 'loose tongue' that could blab secrets, rumour or slander. This is a specific example of the common belief that parts of the body are independent agents and that they can be good or bad. This belief, and the associated one that a part of the body can be an enemy of the other parts, is reflected in the often quoted verse in both Mark's and Matthew's gospels, that *'if thine eye offends thee, pluck it out'*.

### ***(c) Mutilation of children***

Mutilation is not only motivated by ridding oneself of something but may also be aimed at an improvement of the body. This is most apparent in the mutilation of children, and though this may be an uncomfortable topic for some readers we make brief mention of it to illustrate how readily the anti-trauma safety-catch can be released when a society provides 'directions' about what is acceptable or desirable.

Children's bodies are rarely modified in the West, but child mutilation was widely practised in many other cultures and is still socially sanctioned in some. The motives for mutilation on children are not

always clear, but aspiration to an aesthetic ideal is certainly one. For example, the ancient Maya Indians would hang an object close between a baby's eyes in the hope that the child would grow up cross-eyed, a condition which they saw as beautiful. Other examples include the foot binding that was carried out over many centuries on children not only in China but also by the Kutchin Indians in Alaska.

It has been suggested that the mutilation of infants and the very young in some cultures might also serve to increase their viability and resistance (Landauer & Whiting, 1963), effectively hardening them ahead of the challenges they will face in adult life. Some of these 'hardening practices' involve damage to the skin through scarification (cutting or abrading the skin to form raised keloid scars), cicatrization (where the skin is cut and rubbed with ash producing inflammation and a pronounced, raised scar), piercing, cauterization or circumcision. Others like head moulding and limb stretching do not involve skin damage. Whether these procedures actually confer any physical or psychological advantage is unproved, although Landauer & Whiting observe that individuals in cultures where such traumatic hardening is traditional tend to grow significantly taller than individuals in societies where the practice is uncommon. They also note that parents in many native cultures commonly view such hardening procedures as beneficial to their children's health.

#### ***(d) Mutilation continuing into adulthood***

Some mutilation beginning in childhood is then continued into adult life. Cranial deformation was once widespread dating back to 45,000 BC though it has now almost completely disappeared from contemporary cultures (Gerszten & Gerszten, 1995). The head was shaped or flattened by applying continuous pressure to an infant's head using boards or constricting bands with adjustments made as the child grew older. Another example, perhaps more familiar, is seen in Padaung hill-tribe of Burma who consider a long neck to be beautiful and stretch the necks of their women using brass rings. The procedure is begun at the age of 5 with extra rings added each year. By adulthood, the neck can have been lengthened by as much as 38cm giving rise to the term 'giraffe-women'. Any woman whose neck had been stretched in this way is, however, unable to drink from a cup and would choke if the rings were removed – which was sometimes carried out as a punishment.

#### ***(e) Castration and genital mutilation***

Castration of boys has been reported in Sumerian texts from the 21<sup>st</sup> century BC, and is widely recorded in many world cultures. Eunuchs were often preferred for domestic or personal duties in royal courts, and rose to positions of great prominence. Boys were castrated, probably with the agreement of their families, in Italy in sufficiently recent times for there to be a vocal recording of

one. The intention was, apparently, to provide soprano choristers for all-male church choirs. Castration might involve crushing the testes, removing the scrotal sack and its contents, or removing the penis and the scrotal sac and contents.

Genital mutilation not associated with castration is still widely practiced in sub-Saharan Africa and amongst Jews, Muslims, and sporadically in European populations too. Male circumcision has dwindled to become a largely symbolic procedure, but generations of men have had their foreskins removed either for religious reasons or because the glans penis is 'cleaner' as a result (a superstition which has been supported by recent research on the sexual transmission of disease). Much more extensive female circumcision is still sometimes practiced, and this results in significant anatomical change which may cause life-long pain and urogenital dysfunction (Chen *et al*, 204). The sexual mutilation of women, sometimes voluntarily undertaken, has also involved amputation of the breasts and sometimes the labia.

#### ***(f) Cultural determinants of the body***

The many examples of the lengths that people will go to re-arrange the anatomy of their sexual organs is a striking example of the fact that shape is not just a biological given. It is a personal expression. In fact, it is more than that. It is expected that men will be circumcised in many cultures, and in these cultures the appearance of the genitals is a cultural identification. It is important to remember that this is not just something that occurs in other cultures or something that makes these cultures 'primitive'. In the section that follows we will see that our own culture is one in which the skin is increasingly seen as an organ of self-expression, and in which it is becoming unfashionable not to decorate the skin in some way, either by piercing, painting, or depilation.

Mutilation is also an everyday part of Western culture, although we do not recognize it so easily as in other cultures. Plastic surgery may be a way of repairing an appearance altered by injury or illness but more often than not it is a means of creating a new appearance, one that is an expression of cultural ideals rather than bodily potentiality. The boundary between what is 'natural' and what is 'artificial' shifts as culture shifts. Western culture currently thinks that it is appropriate to alter the sexual anatomy of children whose genitalia are ambiguous, but many adults who had this operation as children now argue that it is an inappropriate mutilation.

#### ***(g) Mutilation and difference***

Mutilation is often associated with shame or shaming. Shame is the perception that one is flawed, that the flaw is perceived by others as bad, and that they are right to do so (Tantam, 1998). Shame that is not hidden can sometimes be overcome (Tantam, 1991). Difference can be experienced as a flaw if others stigmatize it so, but if displayed with pride others may accept that valuation. There is, however, a price even so. A person who is different cannot personify the norms of their culture. If they do achieve a valued status, it is one of those that exist on the edge of the social group: the wanderer, the hermit, or the fakir for example.

Celebrated literary figures who have been mutilated include Oedipus whose feet were nailed together before he was exposed and left to die on a mountain as a baby, and the monk Xuan Zang who is the hero of the Chinese novel known in English as *Monkey* or *The Journey into the West*. Xuan Zang was, like Moses, entrusted to the river when he was a baby but his mother bit off one of his toes before abandoning him so that she would know him again. Both Oedipus and Xuan Zang became wanderers, both suffered many trials and setbacks, and both ultimately achieved powers denied either men. They have become icons of transcendence.

#### ***(h) Mutilation, blindness and the blind seer***

In the previous examples, Oedipus and Xuan Zang both had mutilated feet. But the mutilation most associated with transcendence is blinding. Oedipus blinded himself when his unwitting incest with his mother Jocasta was found out. Tiresias (a character in several plays by both Sophocles and Euripides) was a priest who saw two snakes having intercourse, a dangerous icon of Godhead in Indo-European culture; in some tales, he was turned into a woman after striking the female snake, only to turn back to a man after seeing two coupling snakes again and striking the male snake this time. Tiresias was blinded by Hera for taking Zeus' side in a quarrel and given the gift of prophecy by Zeus as recompense.

Blind seers also occur in other cultural traditions. Soordas (Surdas) is a historical figure and a composer of many spiritual songs in the 15<sup>th</sup> century. Like Xuan Zang, Soordas learned the many scriptures that he knew from oral recitations as he was born blind. However, legend has it that he was struck blind because he saw Lord Krishna in the flesh. Tradition also has it that Odin (derived from 'odr' meaning excitation, fury or poetry) the chief of the Norse Gods gave his left eye to the giant Mimir in order to gain the wisdom of the ages. Zhang Lang, a Chinese legendary figure, was blinded for adultery but was restored to sight by his wife only to be so ashamed to see her that he jumped into the hearth and was almost wholly consumed by fire. However he was subsequently deified and now, as God of the hearth, monitors the behaviour of family members and reports to the Jade Emperor on any irregularities in the houses of which he is the tutelary or guardian spirit.

### ***(i) Mutilation, rites of passage, and the limen***

Mutilation is particularly associated with ceremonies to indicate that a child has become an adult. The first systematic account of these 'rites de passage' was in the book of that name by the Franco-German anthropologist, van Gennep (Gennep, 1961). Van Gennep considered that there were three phases to a ceremony of this kind: separating the person whose status was changing from their peer group, a threshold or liminal stage, and then a reincorporation stage in which the person joins their new peer group. A person's identity during the liminal stage is weakened and new, unexpected or threatening experiences often contribute to this. The adolescent may be sent off to live alone in the hills, or in the sweat lodge, or to keep vigil at a shrine. Expectations may be jumbled up. Young men may cross-dress or be used by adult men homosexually. Class and totem distinctions may be lost.

Injury is often an important element of this. The Masai's treatment of adolescent boys, which inspired Baden-Powell to found the Scouting for Boys movement, involved a night during which boys were expected to plunge an assegai (a short, stabbing spear) into their thigh. Humiliation, too, seems to play an important part as is apparent in many of the initiation ceremonies to adolescent groups such as American University fraternity and sorority houses, motor cycle gangs, and armed forces corps.

### **Self-sought mutilation**

Punishment mutilation and the mutilation of children are socially directed and may be considered ethically acceptable, at least within the cultures in which they are performed. Mutilation carried out by a person him or her-self, or by another at the person's request, often targets the same body parts that are considered agents suitable for judicial punishment. What makes it different from judicial mutilations is that the action is not socially directed, at least not by official society. These mutilations are usually considered either mad or bad, and may therefore be concealed from others. The frequency of self-mutilation may be under-estimated because of this concealment.

Clinical experience suggests that it is extremely rare to find one clear and sufficient reason to explain self-mutilation. More often than not the significance of self-mutilation is like the significance of mutilation by others – multiple, with several different meanings. Psychologists often use the adjective 'over-determined' to indicate behaviours that serve more than one function simultaneously and self-mutilation is frequently described in this way.

### ***(a) Self-mutilation for profit***

Self-mutilation may be justified as an unwelcome but necessary by-product of some instrumental goal – an unpleasant but necessary ‘means to an end’. These goals include evading duties as with the soldier who injures an eye or shoots himself in the foot to avoid active service, or with African slaves in the 19<sup>th</sup> century who chopped off their fingers so as to be unable to work for their masters (malingering); increasing one’s income as a beggar; obtaining medical services (a kind of Munchausen’s syndrome); or forcing a surgeon’s hand. In recent years, most of the reports of the latter have been of mutilation of the genitals by people seeking gender reassignment surgery (Shubin, 2003; Murphy *et al*, 2001). Some easing of the safety catch seems a necessary condition for this kind of self-mutilation, and there may be practice attempts before the final mutilation takes place. Weakening of the safety catch may be one reason why there seem to be a disproportionate number of reported cases of surgeons using self-mutilation to make themselves unfit for work and eligible for insurance payments (Puschel *et al*, 1998).

Individuals with factitious disorder repeatedly and deliberately display symptoms of illness and may inflict damage on themselves to create physical symptoms. The motivation appears connected with a need to remain in a sick role and receive repeated attention from medical staff. In *dermatitis artefacta*, for example, the skin is picked, abraded or damaged with caustic substances to simulate lesions, apparently in attempt to feign a dermatological condition. Babiker & Arnold (1997, p.8) suggest several features that distinguish these behaviours from the cutting and burning performed by those who repeatedly self-injure; in factitious disorders there is often less awareness of psychological distress, attention from a professional or other carer is always sought (and as often avoided in private self-injury) and damage to the body is not an end in itself.

Some would say that gender reassignment surgery is itself a kind of self-sought mutilation. The much rarer self-amputation of limbs may be motivated by a person’s belief that ‘being an amputee is a critical aspect of their identity’ (Berger *et al.*, 2005) although it may also be motivated by the delusion in a person with schizophrenia that the amputated limb contains a transmitter or some other device causing hallucinations or interference with thinking.

### ***(b) Self-mutilation and psychosis***

Mutilation may not just be associated with schizophrenia, but can occur in drug-induced psychosis, delusional disorders, mania and severe depression. Self-mutilation during psychosis may be performed in response to command hallucinations or delusional beliefs. Like other acts of aggression in people who are psychotic, drug or alcohol intoxication often contributes. The mutilation may be severe enough to prompt attempt at surgical repair or it may be irreversible such as when an eye or

limb is removed. It can certainly be fatal. Psychotic self-mutilation appears to be considerably more common in men than women. Whilst this may be an artefact of the way data has been gathered (Greilsheimer & Groves, 1979) it is widely recognized that men generally have a greater propensity to perform violent or extreme self-damaging acts. Self-mutilation in psychosis is reviewed by Grossman (2001) who draws attention to the reduced sensitivity to pain that occurs in many psychotic states. He cites an interesting early study in which 37% of a sample of schizophrenic inpatients with acute appendicitis did not report any pain (Marchand *et al*, 1959). Since acute appendicitis is well-known to be excruciatingly painful, this degree of insensitivity is remarkable and may go some way to explaining the disinhibition some psychotic patients demonstrate towards the type of self-damage that most people find impossible to contemplate.

Gossman (2001, p.53) cautiously observes that a previous history of self-mutilation can be identified from literature reviews as a potential risk factor for major genital mutilation. In one small clinical series of 14 patients, two thirds were psychotic at the time of the injury and nearly a third injured their genitals more than once. Interestingly, it was the patients who were psychotic were most likely to repeat (Aboseif *et al*, 1993). Reports of amputations and other severe self-mutilation and amphetamine-induced psychosis (e.g. Kratofil *et al*, 1996; Israel & Lee, 2002) are particularly frequent. Religious delusions appear quite commonly in cases of genital mutilation (Simeon & Favazza, 2001, p.8) where, typically, the sufferer interprets certain passages from the Bible or other religious texts in a very literal way (Nakaya, 1996). Self-enucleation of the eye has also been linked to religious delusions (Ananth *et al*, 1984).

Although it is customary to consider self-mutilation as having little similarity with other kinds of self-injury, the increase in risk reported in cases of chronic intoxication (Moskovitz & Byrd, 1983) is probably due to the development of, and access to, altered states of consciousness. This may also explain the development of repeated self-injury, as we shall see. Self-mutilation may also be contagious, just like other kinds of self-injury (Alroe & Gunda, 1995).

### ***(c) Self-mutilation and the religious significance of castration***

Whilst self-mutilation may attract social opprobrium or scorn, it may also be seen to offer some of the benefits that can be associated with mutilation – such as wisdom, maturation, or overcoming shame. Acts of self-mutilation, sometimes so severe as to lead to death, occur more frequently at times of social change or crisis and seem to serve a catalytic function by accelerating the process of change. Durkheim termed suicide of this kind ‘altruistic’ suicide, arguing that it occurred when an individual’s self-consciousness was weakened and they were prepared to put the welfare of the group first.

Of the many possible examples of this kind of mutilation, the Skoptsi stand out. The Skoptsi were Raskolniki or Old Believers, traditionalist Russian Orthodox adherents who rejected the modernization of the liturgy by Muscovite church leaders. Many of them were peasants who believed that the Tsar and the Patriarch were worshippers of Satan, that serfdom was their instrument to bring about Satan's rule, and that Armageddon was near. The Old Believers were involved in the Moscow Uprising of 1682 and many of them migrated after this was crushed. Some immolated themselves (burned themselves to death) inspiring Mussorgsky to a disturbing ending to his opera, *Khovanshina*, in which the Old Believers who are portrayed as ignorant bigots get burned alive. However the greatest blow to the Old Believers and the traditions to which they cleaved were the Europeanizing reforms of Peter the Great. These involved sweeping away everything for which the Old Believers stood, and it was in this context that the Skoptsi extremism emerged.

The Skoptsi made self-mutilation (the 'baptism of fire') a central part of their rite, and also of their identity. It has been estimated that only a minority of Skoptsi mutilated their sexual organs but those that did were looked up to as leaders. Men either amputated the scrotal sac and women the breasts (the lesser seal), or members of either sex removed all of their external genitalia (the greater seal). The Skoptsi first came to attention in the 18<sup>th</sup> century when it was discovered that two peasants, Andrei Ivanov and Kondratii Selivanov, had persuaded 13 other peasants to castrate themselves. Although Ivanov and Selivanov were prosecuted and exiled to Siberia, Selivanov escaped. Claiming that he was the son of God and Peter III and a reincarnation of Peter the Great (a curious boast for the leader of a sect who regarded Peter as Satan), he recruited followers (Shubin, 2003). The numbers of these increased so that in the late 19<sup>th</sup> century they were estimated at over 5000, with nearly a thousand of them having undergone the 'baptism of fire'. For some reason, Skoptsi were particularly common amongst money lenders.

The Skoptsi had antecedents in the Corybantes, males priests and celebrants of Cybele or her consort, Attis, who danced their way into manhood or at times of victory. Catullus describes some of them castrating themselves during their religious frenzy. Religious fervour since the Skoptsi died out in the early 20<sup>th</sup> century has rarely resulted in castration although mass poisonings have occurred and there are occasional, sporadic reports of self-castration (Sokalingsam & Stergiopoulos, 2005).

#### ***(d) Self-mutilation and other offending organs***

The eyes are, as the Biblical passage suggests, the other organ that is most likely to offend since the eyes provide us with knowledge of scenes and events about which we would rather be ignorant. We also use our eyes, and thus make ourselves responsible for what we see. Oedipus, in the Sophocles play, blinded himself to spare himself the sight of his children, a constant reminder of his shame in lying with the woman (Jocasta) who was both his and their mother. Sophocles has him say *'Wicked, wicked eyes! You shall not see me nor my shame. Not see my present crime. Go dark, for all time blind to what you should have never seen'*. Severe self-inflicted ocular injury is rare but people,

particularly young men, do sometimes blind themselves (Patton, 2004). Less severe injuries caused by motor stereotypies like rubbing the eyes hard or hitting the fist or the ball of one's hand into the eyes may also lead to retinal damage and impaired vision, although it is doubtful that this is the aim of the stereotypy.

### ***(e) Self-mutilation and suicide***

Most people think of self injury in terms of suicide, as a 'suicide attempt'. People can injure themselves whilst trying and failing to kill themselves, but this amounts to only a very small proportion of all self-injury. The commonest means of suicide in the West is by taking an overdose of medication and does not involve self-injury at all. Burning is a commoner method of suicide in other parts of the world and may be carried out under social pressure. In India, for example, there has been an increase of deaths by young women who have poured kerosene (paraffin) over themselves and then set fire to it. The motive seems to be to escape the shame and criticism from their husband's family of having failed to bring the dowry that was promised before marriage. Other associations with self-immolation are political protest (India and South East Asia) and psychosis (Europe and Middle East), but despite their varied motives people who burn themselves do not injure themselves in private (Laloe, 2004), and people who do injure themselves in private rarely go on to set fire to themselves.

### **Mutilation, transformation and social change**

The idea that society has a body with the same anatomy as the human body has been traced back to the Rig Veda of the second millennium BC, and the Zhou documents of the Western Han. Aesop's fables, Shakespeare's *Coriolanus*, and Hobbes' *Leviathan* are among many other instances of the same simile. It is not therefore surprising that there seems to be a link between transformations in the body politic and the prevalence of bodily transformation. As previous examples in this chapter have demonstrated, some of the most extreme practices of mutilation occur in cultures undergoing transformation. Many cultures provide social directions about when mutilation is appropriate and when it is condemned. During rapid social change, when society is transforming, there is greater tolerance of experiment and that could be an explanation of why there is also greater tolerance of mutilation and, therefore, why mutilation occurs more commonly.

However, there may be other links. The strong connection between mutilation and religion on the one hand, and between mutilation and parts of the body associated with desire on the other, suggest that mutilation may present itself as a means of controlling social disorder by controlling

disorderly feelings. Legitimate, socially directed mutilations seem to be particularly associated with transitions and social upheaval. Could this also apply to private, illegitimate, mutilation?

Before considering this, it is worth considering the circumstances in which a culture of mutilation develops. The Skoptsi developed in response to the transformation of the old into the new, Europeanized Russia. There is, many people have argued, a link between the 'body politic' or society and the individual body. We think it likely that under conditions of rapid social change, the conditions which conduce to the increase in suicide including altruistic suicide about which Durkheim wrote, there is a reduced investment in the sanctity of the body and a greater willingness to undertake bodily transformation.

How could this link be mediated? Durkheim suggested that it was through 'altruism', that is a reduction in mutilation (whether by others or by a person themselves) may be socially directed. Within a culture in which this occurs, no other explanation of the mutilation needs to be given other than that the person was particularly devoted or committed and thus a particularly strong exemplar of the culture.

## **Augmenting the body**

### ***(a) Body modification***

Body modification that does not result in anatomical change is much more common than the kind of body modification or self-mutilation that is aimed at rearrangement of body parts. Body modification may be carried out by others, but if carried out on adults it is normal for them to consent to participate. Like self-mutilation, it is usually self-sought. It is often socially directed towards an outcome that is social desirable. Even if the activity is not socially directed, the result is rarely considered shameful and may either be flaunted or, at the least, selectively revealed with pride. Body modification may even be used as a specific against shame. Women who have been sexually abused and been unable to enjoy sexual experience subsequently because it makes them ashamed have described being able to experience genital satisfaction after genital piercing.

The body may be augmented chemically, for example by anabolic steroids or sex hormones or by the insertion of implants. Most of the current implants are designed and inserted by medical staff. They include prosthetic limbs, stents to strengthen blood vessels, pumps to supply insulin, valves for the heart and for the flow of cerebrospinal fluid, artificial joints, artificial cochlears, and pacemakers. In the future it seems likely that the science fiction writers will prove to be true prophets, and that augmentation will extend to devices that boost the senses or the power of the muscles.

Most non-medical devices that are used for body augmentation are used either for decoration or for altering sexual function. Unusual examples of decorative devices are those that are used to augment clothing. Prince Albert reportedly had a device inserted into his penis to hold his scrotal sack to one side so as to remove the bulge in his trousers, and some Roman soldiers had inserted a ring inserted into their nipples in order to attach a cord to hold their cloaks. Stirn provides a brief but exhaustive guide to all of these augmentations and to the skin piercing that accompanies their insertion (Stirn, 2003).

Other body modifications (listed by Encyclopaedia Britannica, 1991, p.318) include removing digits, chipping or filing the teeth (in Africa, central America and Borneo) or removing individual teeth (Australian aborigines and Western orthodontists), breast shaping by compression (in the Caucasus in Spain in the 16<sup>th</sup> and 17<sup>th</sup> centuries) or by distension (among the Payagua of Paraguay), penis lengthening and silicone implantation under the skin (Western cosmetic surgeons), fat removal or injection (Western cosmetic surgeons), and selective irreversible muscle paralysis via use of Botulinum A toxin complex or 'botox' (Western cosmetic surgeons). These modifications are only minor anatomical rearrangements and are not designed to have substantial effects on bodily function.

### ***(b) The skin as a canvas***

Much the commonest means of altering appearance is by changing the appearance of the skin itself. Skin painting and skin dyeing are so common that we hardly noticed them. We take for granted that people's eyes are highlighted by eye-liner or eye-shadow which may contain sympathomimetics like kohl which enlarge the pupil. We also take for granted that their lips are emphasized by red pigment, the skin of their faces are made to look more healthy with coloured lotions, and their cheeks flushed with 'blusher'. The hair, too, is routinely dyed. These practices have, in Western culture, been largely restricted to women for the last few centuries although it has continued to be the norm for men to apply body paint in specific social situations such as circuses and theatres and, more recently, amongst football, cricket and rugby supporters when attending key events.

Permanent changes in the skin can be achieved by burning or 'branding', by deliberate scar formation, or by inserting pigment intradermally either by rubbing it into cuts or by pricking it in. Branding is a common method of marking cattle and is not used for decoration but for identification of people with low social status such as criminals and prisoners. Scars are usually less pigmented than the surrounding skin, so scarification is particularly effective in darker skins especially as it may then be combined with a greater tendency to keloid formation leading to a particularly thick and exuberant scar. Scarring can be increased by rubbing foreign material like ash into the injure, or by holding the edges of the injure open. The Huns are also thought to have used scarification as a form of skin decoration, but other than the brief fashion to have a duelling scar on the cheek which was sometimes deliberately simulated, the popularity of scarification has not revived in Europe. It is

becoming less common in Africa, too, although it is becoming more common in small groups of skin decoration aficionados in the US.

Tattooing is a more effective decoration for paler skins. It is an ancient practice, possibly dating back to the Neolithic period. It may be combined with scarification, as the Maori do. Tattooing and scarification were proscribed by the early Christian Church, perhaps basing the prohibition in [Leviticus 19:28](#): *'Do not make gashes in your skin for the dead. Do not make any marks on your skin. I am God'*. Muslims also believe that tattooing is a desecration of God's creation.

Possibly because of their religious proscription, tattooing and cicatrisation have gained a sinister connotation in the West, which tattooing it is now rapidly losing. Tattooing was common among Vikings and Mediterranean peoples in Europe but died out with the suppression of non-Christian religions until it was reintroduced by sailors accompanying explorers to the Pacific, where being tattooed was and is an important mark of personal identity.

Whilst most tattoos are self-sought, tattooing has also been used to identify people, for example in the Nazi concentration camps. Branding, another method of permanently altering the skin's appearance has also been used to identify slaves and criminals, although it too is now becoming an accepted type of 'body art' (Karamanoukian *et al*, 2006). Body art is well on its way to coming back to being a socially directed activity in the West. Students in one large survey (Armstrong *et al*, 2004) who had a tattoo were most often recommended to get it by a friend or by a sister (but not by another family member). Nor did they differ in background or religious affiliation from the students in the survey who did not have skin decorations. The only correlation in the survey was between body art and sexual activity and this was probably due to the students having tattoos being more ready to take risks, and therefore to be innovators. Both early sexual intercourse and body art carry some element of risk of infection and social stigmatization (having a tattoo may reduce a person's chances of getting a job, for example).

Tattoo-ists in Western culture commonly consider tattoo-ing and other 'body art' as merely an act of decoration and therefore not different in kind to applying make up or hair dye. Evolutionary psychologists sometimes support this, suggesting that body modification confers survival advantage by exaggerating the secondary sexual characteristics (Singh & Bronstad, 1997).

This does not entirely explain why people are willing to tolerate sometimes considerable pain during body decoration, nor why people get tattoos to mark important transitions such as overcoming a long-standing or severe difficulty. Ludvico & Kurland (1995) analysed body modification data obtained from 186 societies throughout the world contained within the 'Standard Cross Cultural Sample'. They took a broad view of scarification (from piercing and tattooing through to injure-mediated mutilation) and tested four hypotheses of its function: (1) as a rite of passage or symbol of initiation into another group, (2) as a traumatic hardening procedure performed on infants with the aim of increasing viability and resistance, (3) as adornment to attract sexual partners and confer a mating advantage, and (4) to demonstrate an individual's resistance to pathogens to members of the

opposite sex and their parents, again to attract sexual partners. Ludvico & Kurland noted that a global pattern remained elusive, but found support for the 'rites of passage' hypothesis world-wide, and in three continents if genital mutilation was included, and also for the 'adornment' hypothesis worldwide if piercing was included. The fourth hypothesis (to demonstrate resistance to pathogens) was only supported in North America.

Tattooing provides the opportunity to make a lasting, commemorative mark. It is reported in this connection that the contract between Captain James Cook and the Maoris with whom he made contact as the first European to reach the Antipodes was tattooed on the skin of one of the Maori elders. Common tattoos include the word 'mother' or the names of sexual partners, and may represent a kind of contract to remain loyal to the person named comparable to that of the Maori chieftain's tattoo of the pact with the UK. Other common tattoos are religious symbols and dangerous animals. These may be chosen for protection, to identify the wearer with the spirit of the animal, or to gain power by association.

### **Compulsive and stereotypic self-injury**

Getting a tattoo is unequivocally an action, something that one chooses to do, even if the decision is made only moments before and is regretted immediately after. In a commonly cited classification of self-injury (Favazza, 1998), cutting one's wrist is considered to be similar to getting a tattoo, and both are classified as impulsive actions and contrasted with the self-mutilation that we have considered above (termed 'major self-injurious behaviour' by Favazza) and self-injury that does not seem to be an action at all, but something more like a bad habit. This 'compulsive' self-injury often starts from self-grooming behaviours like playing with the hair – which can lead to tugging the hair, and then pulling the hair out (trichotillomania). Other examples include nail-biting (onychophagia), nose picking (rhinotillexomania) and picking at the skin (neurotic excoriation). These disorders are more common in women, begin typically in the late 30s, and are often associated with a history of mood disorder and substance abuse (Arnold *et al*, 1998).

In people with learning difficulties or people who are socially isolated the grooming behaviour can be more extreme, for example striking the eyes (sufficiently sometimes to lead to blindness), finger chewing, gum biting, or head banging. All of these behaviours are within the normal range: head banging or hair pulling, like clothes ripping, are part of the repertoire of people in extreme grief, for example. Injuries, when they occur, are the unintended consequence of the grooming. The forehead and the backs of the hands appear to be the most common target sites (Symons & Thompson, 1997). The individual appears to derive little satisfaction from the behaviour which is often repeated over and over again, rhythmically or occasionally in sudden outbursts. The prevalence of stereotypic self-injury amongst those with learning disability has been reported in the range 17 – 24% (Deb, 1998), although Stein & Niehaus (2001, p.30) note that other estimates have ranged from as low as 3% to as high as 46%. It may be more common in females and is particularly associated with Lesch-Nyhan,

Prader-Willi, Tourette, and Cornelia de Lange syndromes. Such behaviours tend to be repeated many times each day and have a ritualistic quality about them. Unlike self-cutting, they are frequently performed automatically, often compulsively, and without any conscious urge although inhibiting them can lead to discomfort.

Lack of social contact seems to be an important element in this kind of self-injury. It is therefore particularly associated with conditions that break social bonds; examples include children who have been neglected and so have become withdrawn, people with autism, and prisoners who are kept for long periods in solitary confinement or who are treated with implacable hostility by their captors. The similarities with cage stereotypies in zoo animals has often been remarked upon, as has the link with the stereotypies seen in amphetamine users. The link is dopamine.

Dopamine is sometimes called the 'reward' transmitter. Dopamine release is increased by social reward. Conversely, dopamine levels drop during social deprivation. The susceptibility to dopamine reduction, and to stereotypy, is increased by social deprivation during early development in animals and probably in humans too (Breese *et al*, 2005). Dopamine is also released by grooming. It is likely that when social reward drops as a result of social isolation, especially in people who have been sensitized by early deprivation, grooming provides an alternative to social reward. Inevitably, conventional self-grooming quickly becomes insufficient, and more and more intensive and repeated grooming replaces it.

There is some evidence that the other group who are at particular risk of self-harm in custodial settings are those who are diagnosed as having psychopathy. Individuals who are so diagnosed are reported to have relatively higher dopaminergic activity when compared to serotonergic (otherwise termed '5HT-mediated') neural activity. This suggests that there may be a different route to self-injury in people who are diagnosed as psychopathic and whose self-injury is sometimes attributed to 'impulsivity'. However studies of women who self-harm in custodial settings indicates that their scores on factor 1 of the Hare psychopathy checklist (measuring the affective/interpersonal dimension) were negatively associated with self-harm. That is, women with the coldness towards others that is often associated with psychopathy (which may be a consequence of low serotonergic transmission) were less likely to harm themselves. In contrast, women who scored highly on factor 2 of the Hare checklist (measuring the antisocial/deviance dimension) were more likely to harm themselves, and this was attributable to their childhood experience of physical abuse (Verona *et al*, 2005). 'Psychopathy' as the term is currently used therefore seems to be a heterogeneous category in which there may be impulsivity and low mood associated with low serotonergic transmission and a second component resulting from physical abuse which might be associated with low dopamine (Joyce *et al*, 2006).

Compulsive self-injury is associated with particular conditions in which there is congenitally low dopamine such as Lesch-Nyhan syndrome. However, neither low levels of dopamine nor the self-

grooming type of self-injury seem to apply to deliberate acts of self-injury, although they may apply to other kinds of self-injury seen in adulthood such as compulsive hair pulling.

We disagree with Favazza in considering that self-injury is unequivocally an action, like getting a tattoo. There is certainly some self-injury that is like this as we have discussed in the previous section. But repeated self-injury does lead to injury becoming more sudden, and apparently automatic, like tearing one's hair (we consider this in more detail in chapter 4). Much of the private self-injury that we consider in this book is not consciously goal-directed, nor is it the means to an end as tattooing is the means to the end of skin decoration. It is the end. Like compulsive self-injury, people who have repeatedly injured themselves to the point where further injury becomes compulsive may be unaware of the injury, or themselves causing it, until after and may even deny that they have done it. We consider this phenomenon, an instance of dissociation, further in chapter 4. We have to conclude again, as we did in chapter 1, that private self-injury is both action (like tattooing) and behaviour (like hair pulling), but rarely either fully one or fully the other.

## **Pain, ordeal, and the skin**

### ***(a) The significance of pain***

One difference between compulsive self-injury and other kinds of self-injury is that compulsive self-injury occurs more frequently when pain sensation is diminished. Although pain may sometimes be shut off in people who injure themselves in other ways, this is not reliable and indeed pain may, paradoxically, be why the person injures themselves and not the other way around.

Even having an ear lobe pierced can be painful, and having a complicated tattoo, an incision into the penis, or the insertion of a ring into the tongue or the clitoris may be exquisitely so. 'Masochism', the association of sexual excitation and the experience of pain, is sometimes given as an explanation of why a person might seek out a painful experience. 'Venus in furs', the novel by Leopold van Sacher-Masoch that provided Kraft-Ebbing with a name for this sexual fetish is, in fact, entirely concerned with the association of humiliation or emotional suffering with sexual excitement. Experiencing pleasure from pain is an uncommon kind of sexual fetish and self-injury occurs in a sexual context only rarely. So sexual masochism cannot explain why the pain of everyday self-injury may be sought after.

### ***(b) Torture and ordeal***

Aldrich and Eccleston (Aldrich & Eccleston, 2000) asked 54 people chosen to be from varied backgrounds to rank 80 statements about pain from the most to the least apt. Their responses were then further analysed leading to 8 'accounts' of what pain means. These accounts were that: 1. pain is a signal of malfunction; 2. pain is a spur to self development; 3. pain is a spur to spiritual development ('pain raises us to a higher plane of understanding and experience, it is mind altering like a drug', said one respondent); 4. pain is an alien invasion, a destroyer; 5. pain is located in the body, and provides useful information about when something needs to be fixed; 6. pain comes from abuse by others; 7. pain protects us from doing the body harm; and 8. pain enables us to share the experience of those who have been harmed, it is an antidote to power.

The pain that is the transformer of the self, either for self- or spiritual development or for destruction (accounts 2, 3, 4, 7 and 8) is pain that is deliberately inflicted by self or others. Skin damage is one of the simplest methods of causing deliberate pain and is a common method of torture. The notion of torture is simple. The truth is extorted by pain. A person who has a secret is forced to divulge it by the threat of further, intolerable, pain.

The reality is less simple. The evidence provided by people who are tortured is often spurious and unreliable (Saul, 2004): understandably, because the torture victim only wants the pain to stop and not to assist the torturer. So what torturers aim for is to destroy the identity of the torture victim so that the victim no longer has any reason to lie or conceal the truth, but complies without resistance. The process is most effective when the victim has no particularly strong beliefs in the first place, and least effective when the victim has a political or ideological commitment that cannot be broken. The impact of torture is also augmented by the loss of control that the tortured are forced to endure (Rivera-Fuentes & Birke, 2002).

Loss of identity following torture can be so great that it has been termed 'mental death' (Ebert & Dyck, 2004). Mental death is, these authors argue, one of the factors that leads to particularly incapacitating post-traumatic stress disorder. But mental death can also be the prelude to rebirth. This is not the case when it is the consequence of meaningless and ill-intentioned harm by others. But it may be the case if pain occurs as the result of a self-imposed ordeal. One reason therefore that a person may seek pain through self-injury is to efface an earlier identity, so that it can be replaced by a new one.

### ***(c) Religious ordeal***

Self-injury and self-injury have been frequent practices of religious people seeking self-abnegation through pain in order to experience a new identity through mergence with their god, or at least to replace their old self with a new (Glucklich, 1999). The Tibetan Book of the Dead contains an account of Sikyamuni Buddha allowing a tiger to eat his flesh. Sufi literature contains many examples of self-injury by Sufi Muslims. The mortification of their flesh by wandering Hindu Sadhus ('fakirs') is proverbial. Ordeal has been important in many other religions too, not least in Christianity. Pain and humiliation are also recurrent themes of religious practice in Muslim, Hindu, and Christian traditions.

St. Josemaria Escriva de Balaguer (Escriva, 1992), the founder of Opus Dei, is an articulate modern advocate. He writes, 'To defend his purity, St. Francis of Assisi rolled in the snow, St. Benedict threw himself into a thorn bush, St. Bernard plunged into an icy pond... You... what have you done?' (ibid, p. 143)... 'Blessed be pain. Loved be pain. Sanctified be pain. . . Glorified be pain!' (ibid, p. 208)... 'If you realize that your body is your enemy, and an enemy of God's glory since it is an enemy of your sanctification, why do you treat it so softly?' (ibid, p. 227)..[and]..'You have come to the apostolate to submit, to annihilate yourself, not to impose your own personal viewpoints.' (ibid, p. 936).

The language of St Josemaria Escriva is militaristic, and there are similarities between his view of pain and that of the pagan soldier who loses himself but gains a new fraternity with his colleagues through a shared experience of injury in battle: what Stephen Crane called the 'red badge of courage' in his novel of that name.

Self-flagellation, the wearing of hair shirts, eating spiny cactus and wearing the cilice of Opus Dei all require considerable determination, but paradoxically the actions are experienced as being carried out in deference to an external authority. They are experiences that reduce autonomy, but increase a person's determination and self-control. Carrying out these disciplines creates a sense of achievement and a means of identification with others who have overcome something similar. The identification may be a concrete one if the act leaves a scar which can be recognized.

Ordeal through its relevance to creating new identifications and establishing autonomy is important in rites de passage, to which it adds an important element of personal or spiritual transformation, but at the risk of self-destruction or 'mental death'.

Private self-injury of the kind that we consider in this book is not carried out in obedience to a higher authority, and it is the injure itself and not pain that the self-injurer is aiming at. In fact, the person may be so focussed on making the injure that the pain is blocked out. This is in marked contrast to someone who has been inadvertently injured whose sensitivity to pain is sharpened (Orbach *et al*, 1996).

## **Injury in an attempt to heal**

### ***(a) Bloodletting to treat physical complaints***

It is difficult to find a country which does not have some history of bleeding its people in attempt to heal them. Maple (1968, p.24) comments that 'bloodletting was as familiar to the Egyptians as to the

physicians of medieval Europe, where every medic worth his salt possessed a bleeding-glass'. The practice appears to have been an almost universal feature of primitive medicine, encompassing Oceania, Central America, pre-Columbian Peru, Brazil, Greece from the time of Hippocrates, and China from the 4<sup>th</sup> Century BC (Ackerknecht, 1971).

Blood-letting was practised amongst many primitive peoples to treat possession, pleurisy, fever and other physical complaints. Some authors have suggested that bleeding may have given relief by 'decongesting the system'. Although decongestion is not a recognized medical concept, blood-letting may have exerted its effect by causing sympathetic stimulation to combat hypovolaemia. There are however two (relatively rare) medical conditions in which bleeding will be temporarily curative: haemosiderosis, an acquired disorder in which iron stores become excessive, and haemochromatosis, an autosomal recessive disorder of iron absorption. Both conditions can lead to progressive organ damage if untreated.

Bleeding was widely practised in Europe in the Middle Ages and appears to have been a regular therapeutic practice in monastic infirmaries as well as among the laity. It may have constituted a type of preventative medicine by encouraging periodic rest, but was probably more often harmful than helpful. It was often criticized by contemporary doctors for causing anaemia, and for being carried out until the patient passed out. Treatment by the laity will have included the surgeon-barbers who not only cut hair but also performed bloodletting. In fact, phlebotomy was so important a service at this time that it established the Barber's Pole as an enduring symbol of this profession. This striped pole still exists as a symbol for barbers in the UK and originates from the earlier practice where the customer who wished to be bled was asked to grasp a wooden staff so that the veins on his arm would stand out sharply. After blood had been let, bandages used to staunch the injury would be hung over this staff which would sometimes be placed outside for advertisement. When these bandages were twirled by the wind, a red and white spiral pattern would be formed that was later adopted for the, now familiar, painted poles. It has been suggested that the half-sphere at the base of the pole represents the bowl originally used to catch the customer's blood.

Bleeding could also be performed using leeches, and the origin of the use of 'leech' as a nickname for a doctor lies in this practice. 'Cupping' was another process for removing fluids from the body. Small vessels were heated and inverted on the skin's surface. Negative pressure was generated when the air within the cups cooled, and the resulting suction led to transudate (including blood) being drawn through the skin.

***(b) Burning to treat physical complaints***

There is a long history of deep injuries being cauterised to reduce the risk of infection, but burning and blistering the skin's surface were also popular treatments in their own right for physical complaints. Burning the skin through blistering (the term 'firing' was commonly used when hot irons were deployed) was at one time a treatment of choice for tendon and ligament strains for humans as well as for horses. Skin burning was achieved through the application of either small heated irons or caustic substances to the skin near to the site of the physical ailment. Two modes of action were claimed: first, the burning was supposed to relieve existing pain by producing a counter-irritation, and second the process led to increased blood flow to the affected part which enhanced the healing process.

### ***(c) Bleeding as self-treatment***

By the 18<sup>th</sup> century there are records of bleeding as self-administered treatment either as a cure or as attempt at prophylaxis against a wide range of complaints and diseases. Conrad *et al* (1995, p.417) note that, at this time, blood-letting together with other physical strategies such as dietetics and bathing were *'thought to lie within the power of the health-conscious layman . . . and it was not unusual for sick people to 'breathe a vein' (let blood), even without the attendance of a barber or surgeon'*. This appears to have been particularly popular in early Victorian rural England where working people were said to greatly value being bled once or twice a year, this often coincident with their biannual visit to the local market. However, they could not always afford professional attention and so attended to themselves.

It may be significant that those with greater wealth preferred to pay others for this treatment, which may indicate a general preference away from self-inflicted skin damage if it could be avoided. A notable exception, however, was the wealthy and eccentric Charles Waterton – an explorer and self-medication fanatic who lived in the early 19<sup>th</sup> century and who claimed to have bled himself no fewer than 100 times. Waterton was convinced of the benefits to his health. His doctors tried to dissuade him from excessively *'tapping my claret'* – as he termed it – but apparently to no avail (Porter, 1992, p.97 citing Aldington, 1948). This eccentric gentleman lived a long and unusually active life and, in common with many of the medics of that time, appeared to believe that draining blood reduced *'deleterious pressure on certain distended vessels'* and had prophylactic as well as curative potential.

### ***(d) Bleeding to treat psychological complaints***

The view that controlled bloodletting was an effective means of restoring an internal balance or homeostasis was widely held in Western culture up until the early 19<sup>th</sup> century, and there are numerous reports of medics from the time of Galen using bleeding as a treatment for psychological as well as physical complaints. Melancholia, for example, was supposed to be caused by an excess of black bile and to be treatable by draining off a quantity of the patient's blood, and there is an

interesting parallel between the bleeding produced by those who self-injure in the 20<sup>th</sup> and 21<sup>st</sup> centuries in response to some internal tension or distress, and this more ancient view of needing to lose blood to restore an internal equilibrium and dispel profound unhappiness. The connection with melancholia certainly suggests an historical link between bleeding and mood, and may imply that physicians of the past had acquired empirical evidence that controlled injury and blood loss could improve the mood in those who are distressed.

Bloodletting was also used in the treatment of those considered to be mad or insane, although this approach was criticized by some. Two conflicting traditions are apparent throughout much of the history of the psychiatric profession: one of rest, support, good diet and conversation, and the other of more medical and invasive treatments (Hunter & Macalpine, 1963; Porter, 1992). It is possible that the former found favour with those treating patients who were quietly or genteelly mad, and the latter with those whose charges were violent or noisy. Whatever the case, bleeding the insane remained a popular treatment over several centuries in Britain and Europe, and at one point an annual Spring bloodletting was routinely deployed at the Bethlem Hospital in London, apparently for every patient regardless of their condition (Porter, 1992, p.290). Interestingly, bloodletting calendars became popular around this time. These encouraged bleeding at times to correspond with the phases of the moon (a link with the concept of lunacy) and were the predecessors of modern almanacs. Bleeding was reported as a widely-used treatment in 19<sup>th</sup> century America and England for so-called 'feminine complaints' including hysteria (Siddall, 1982; Cosman, 1986), and there are records of its use in 1833 as a treatment for bulimia (Parry-Jones & Parry-Jones, 1991).

Bloodletting appears to have begun to fall from favour following criticism by Marshall Hall, a doctor and physiologist from Nottinghamshire, who denounced the practice in his paper '*Observations on Bloodletting*', published in 1830 although it appears that bloodletting and leech application were employed in Europe as a pre-hospital treatment for schizophrenia even until the 1940s.

### ***(e) Conclusions***

The intentional and precise injury of the body by bleeding or burning was, for many centuries, viewed as appropriate treatment for many physical and some psychological complaints. Though often carried out by others, self-treatment certainly occurred and might even have been seen as an individual taking some responsibility for his or her own health. It therefore curious to note the parallel between '*bleeding, purging and cauterising with hot irons*' – once the mainstay of psychiatric therapy and advocated for women with hysterical complaints – and the present situation where many bulimic women cut, burn and purge themselves in attempt to improve their mood and relieve their tension. It is acknowledged that there may be important differences between the (medically endorsed) application of lancet and cauterising iron in the former situation and the self-application of the razor-blade and the glowing cigarette to the skin in the latter. Even so, it would appear that what was once a treatment has now become a complaint to be treated.

## Private self-injury

Private self-injury, which is the focus for the rest of this book, uses many of the same methods that we have already discussed, but it is not socially directed. It has been argued that this is the only difference (Gasperoni, 1998). It ranges from the young teenager who scratches her arm with a pin, to the adult who cuts themselves with a razor blade, burns themselves with an iron, or hits their arms or fingers with a hammer, and has done so repeatedly over many years. We will discuss examples of private self-injury in the next chapter in more detail.

In private self-injury the primary goal is not anatomical rearrangement as it is in self-mutilation. Neither is it appearance as it is in decoration, nor subjugation of the self as it is in the ordeal. Sometimes the effusion of blood may be an important element, and sometimes pain is important too, but the main aim is always the injure itself. People who cut themselves may try to maintain their injure for as long as possible, for example by refusing to have it stitched, by rubbing contaminants into it, or by re-opening it when it starts to close. Some will even go as far as tearing out sutures, or hitting the injure to bruise the surrounding tissue and disrupt the healing process.

What could be attractive about having a injure that one has created oneself? In fact, quite a number of explanations have been suggested and we consider each of these in turn in the next chapter. We note here, however, that the motives of a person who self-injures do differ according to the reasons for the injure. Motives also differ according to whether or not the self-injury is socially directed and, if so, the social circumstances in which it takes place (see Table 2.1). Private self-injury may have similar aims to other kinds of self-injury, including going through an ordeal and getting rid of bad blood or of bad feelings through bleeding. Its primary motive, though, is to create a injure.

Table 2.1 Goals associated with self-sought injury

	Surgery or mutilation	Ordeal	Decoration	Bleeding	Private self-injury
Socially directed?	+/-	+	+	+	-
Relation to shame	not relevant	shaming if not carried out to end	(a) may be shamed into doing it (b) may be ashamed to have done it	may be a means of relieving shame	(a) may be in response to shame (b) scars can be a source of shame

Goal	Anatomical rearrangement by:  (a) creating the body that one was meant to have  (b) getting rid of a part that could spread disease or moral badness throughout the body	(a) subjugation of the self  (b) recognition of one's virtue by others	(a) scar  (b) piercing to receive other decoration	(a) obtaining blood for ceremonial use  (b) getting rid of bad blood  (c) flushing out other 'badness'	(a) the injure itself  (b) pain  (c) blood
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Reviewing the universality, and the perceived benefits, of self-injury as we have in this chapter turns the usual reaction to the person who cuts themselves deliberately on its head. It no longer seems weird that a person might do that, but weird that so many of us do not do it.

The reason we do not is the strong emotional antipathy to cutting into the skin. We have called this the 'safety-catch'. To cut oneself one needs to inactivate this safety catch in some way. We discuss what factors might inactivate the safety catch, and what the consequences of inactivation are in our book, to be published by Palgrave Macmillan.